2

HOLD FOR FIRST AMERICAN TITLE

FA- 19375

Property Address: 8650 Beech

Munster, In 46321

If this Affidavit is to be recorded, the legal description of said property will be attached.

ESTATE AFFIDAVIT

Lois K Seliger, Affiant, states that:

1. Warren D Seliger, deceased, died on the 6 day of FEBRARY, 1989;

2. Affiant is: X the surviving spouse of the deceased,

___ the Personal Representative/Executor-trix of the estate of the deceased;

3. The deceased died: ___ leaving a will which has been probated;

X leaving a will which has not been probated;

___ leaving no will;

4. The deceased and Affiant were married on the 20 day of SEPTEBER, 1947; and were never divorced.
(This item applies only to the surviving spouse.)

5. X All expenses of the last illness and funeral of the deceased have been paid;

6. X All State Inheritance Taxes and Federal Estate Taxes attributable to the deceased and his/her estate have been paid;

7. X There are no claims against the estate of the decendent.

97007065

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

97 FEB -5 AM 10:45

MORRIS W. CARTER
RECORDER

FILED

FEB 5 1997

SAM ORLICH
AUDITOR LAKE COUN.

This Affidavit is made to induce First American Title Insurance Company to issue a policy of title insurance on the above-described real estate.

1-30-97
Date

Lois K. Seliger
Signature of Affiant

LOIS K. SELIGER
Printed Name of Affiant

State of Indiana, County of Lake

Subscribed and sworn to before me, this 30th day of January, 1997.

Melissas B. Lesch
Printed Name of Notary

Melissa B Lesch
Signature of Notary

My Commission expires: 11-24-00

My County of Residence is: Lake

000142

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

HOLD FOR FIRST AMERICAN TITLE

Local No. 54 .... State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Marvin G Seliger
2. SEX: M
3. DATE OF DEATH (Month, Day, Yr): February 6,198[illegible]
4. SOCIAL SECURITY NUMBER: 359-16-0409
5a. AGE—Last Birthday (Years): 64
5b. UNDER 1 YEAR (Months, Days)
5c. UNDER 1 DAY (Hours, Minutes)
6. DATE OF BIRTH (Month, Day, Year): Mar. 22, 1924
7. BIRTHPLACE (City and State or Foreign Country): Hammond, Indian[a]
8. YEAR LAST SERVED IN US ARMED FORCES? N/A
9a. PLACE OF DEATH (Check only one; See instructions): HOSPITAL: ☐ Inpatient ☒ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): St. Catherine Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: East Chicago
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Lois Hacker
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Pattern Maker
12b. KIND OF BUSINESS/INDUSTRY: Pattern Works
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Munster
13d. STREET AND NUMBER: 8650 Beech
13e. INSIDE CITY LIMITS? (Yes or no): Yes
13f. FARM: No
13g. ZIP CODE: 46321
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.): ☒ No ☐ Yes Specify
15. RACE—American Indian, Black, White, etc. (Specify): White
16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+)

PARENTS

17. FATHER'S NAME (First, Middle, Last): Charles Seliger
18. MOTHER'S NAME (First, Middle, Maiden Surname): Elsie Perz

INFORMANT

19a. INFORMANT'S NAME (Type/Print): Lois Seliger
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8650 Beech Munster, Indiana
19c. Relationship: Wife

DISPOSITION

20a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): February 9, 1989 Calumet Park Cemetery
20c. LOCATION—City or Town, State: Merrillville, Ind.
21a. SIGNATURE OF FUNERAL DIRECTOR: [signature] Kuiper
21b. LICENSE NUMBER (of Licensee): FDC 1014511
22. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home 9039 Kleinman Highland, In. FDH 300-

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death.

23a. To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title <
23b. LICENSE NUMBER
23c. DATE SIGNED (Month Day Year)

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24. TIME OF DEATH: 2:22 PM
25. DATE PRONOUNCED DEAD (Month, Day, Year): February 6, 1989
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): NO

CAUSE OF DEATH (SEE INSTRUCTIONS)

27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Cardiorespiratory arrest	3 mos.
DUE TO (OR AS A CONSEQUENCE OF): b.	[illegible]	[illegible] yrs.
DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

28a. WAS AN AUTOPSY PERFORMED? (Yes or no): NO
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

CERTIFIER (SEE INSTRUCTIONS)

29a. CERTIFIER (Check only one)
☒ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed Item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.
☐ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.
☐ MEDICAL EXAMINER ☐ CORONER ☐ HEALTH OFFICER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

FILED

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature], MD
FEB 5 1997
29c. LICENSE NUMBER: [illegible]
29d. DATE SIGNED (Month Day Year): Feb. 6, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): 9112 Columbia Ave - Munster.

SAM ORLICH
AUDITOR LAKE COUN[TY]

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month Day Year): 2-8-89

CORONER OR MEDICAL EXAMINER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
34a. DATE OF INJURY (Month Day Year)
34b. TIME OF INJURY
34c. INJURY AT WORK? (Yes or no)
34d. DESCRIBE HOW INJURY OCCURRED
000113
34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)
34f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

SBH06-004 State Form 10110 Rev. 10/87 DEATH/PD 1